

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Kaci Penick

Date: 08/24/2023

DAS Assignment # 1

Name of the defendant: Benita Martinez, RN

License number of the defendant: RN License #590892

Date action was taken against the license: 11/08/2016

Type of action taken against the license: Revoked

Use the space below to describe the events which led to the action(s) taken against the license. If multiple charges were in play, be sure and cite them, e.g. drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.

Charge I (Patient Safety)

On or around April 19, 2016, Benita Martinez, a registered nurse employed at Lifecare Hospitals of South Texas, failed to adhere to fall precautions for Patient Medical Record Number 14503. The patient had been assigned fall precaution status following a post-craniotomy procedure. At 0700 hours, the patient notified his nurse, Benita Martinez, of his readiness to get out of bed. Unfortunately, within a brief period of that request, the patient was found on the floor of his hospital room, deceased. Earlier that morning, Benita entered the patient's room with the intention of repositioning him. During this task, she deactivated the bed alarm, a device that notifies staff when a patient attempts to leave their bed and neglected to reactivate it before leaving the patient's room. Regrettably, this oversight ultimately contributed to the patient's expiration.

Charge II (Patient Safety)

On or around May 15, 2016, Benita Martinez, a registered nurse employed at Lifecare Hospitals of South Texas, failed to comply with the required guidelines regarding the utilization of gloves and hand hygiene prior to performing a PICC line dressing change, a sterile procedure. This incident involved Patient Medical Record Number 14550. Before beginning the treatment, the patient requested for Benita to wash her hands or apply gloves, which Benita did neither. The patient was unjustly put in danger of potential harm resulting from a systemic illness due to the negligent actions of Benita Martinez.

Use the space below to provide a description of measures you think could have prevented any action being taken against the license and/or would have prevented harm to the patient, if harm occurred.

Several notable measures may have been implemented in order to eliminate the violations that Benita Martinez committed. In the situation of charge I, it is imperative for Benita, a registered nurse, to prioritize fall precautions with utmost seriousness. The use of the fall bundle serves the dual purpose of enhancing patient safety and providing a standardized protocol for nurses to follow. Before departing the patient's room, it would have been prudent for Benita to verify many vital factors: the patient's utilization of non-skid socks, the positioning of the bed rails in the upright position, the adjustment of the patient's bed to a low position and locked, as well as the activation of all security and precautionary systems. Upon receiving notification from the patient that he was ready to get out of bed, it would have been advisable for Benita to communicate effectively with the patient, emphasizing the severity of his condition, and expressing her intention to provide assistance.

Regarding charge II, Benita should have exercised greater caution by ensuring hand hygiene completion and applying sterile gloves before performing a sterile procedure such as a PICC line. Maintaining hand hygiene is a critical requirement continuously expected of nurses on a daily basis. Benita should also have an extensive awareness of the importance of those measures and should understand that they provide the primary means of infection prevention. The patient's desire for Benita to wash her hands or don sterile gloves before performing the treatment is especially important, as it should have served as clear instructions for Benita to adhere to protocols and guidelines. Benita displayed a lack of attentiveness and disregard for the rights, concerns, and most importantly protection of her patient.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical)-

(Charge I) Benita failed to complete the fall bundle assessment for her patient by not assessing her patient for non-skid socks, his bed rails/position, and the activation of security and precautionary systems.

Safety and Security (Emotional)-

(Charge II) Benita failed to promote trust and respect for her patient. When her patient voiced her concern of Benita not performing hand hygiene, that altered the trust the patient had with her healthcare provider.

Standard Precaution-

(Charge I) Benita failed to comply with (Special precaution requirements) / (fall precaution/ Fall bundle) on her patient by not completing a thorough check of security and precautionary systems.

(Charge II) Benita failed to complete standard precaution (Asepsis) (Special precautions as required) by not performing hand hygiene or donning gloves before performing a sterile procedure.

Communication-

(Charge I) Benita did not communicate with her patient about the severity of his condition, and that he should stay in place until her or another healthcare provider could provide assistance.

Critical Thinking-

(Charge I) Benita failed to comply with SBAR and prioritization of tasks/procedure competencies by not checking the activation of the bed alarm on her fall risk patient. She also failed to prioritize his request to get out of bed in a timely manner.

Human Caring-

(Charge I) Benita failed to listen to her patients' needs by not assisting him in a timely manner when he was ready to be transferred out of bed.

(Charge II) Benita failed to listen to her patients needs by disregarding the patient's request for her to use hand hygiene.

Professional Role-

(Charge I) Benita failed to manage her patient's equipment (bed alarm) by not reactivating it before leaving the patient's room.

Use the space below to describe what action you think a prudent nurse would take as the first to person to discover the event described, in other words, you are the one who discovers the patient has been harmed by the nurse or you have discovered the impairment or criminal activity cited in the disciplinary action.

As a prudent nurse, I would have taken additional steps to confirm the policy and procedures specified under fall precautions for the patient. Before leaving the room, I would have taken the necessary precautions to ensure that the bed alarm was activated and that the patient's bed railings were properly positioned and secured. When the patient requested to be transferred from his bed, I would have acted quickly to accommodate him. If I were in the middle of caring for another patient, I would inform him of the severity of his procedure and the dangers of attempting to move without assistance. In addition, the initial action after discovering the patient on the floor would be to conduct a thorough evaluation of the patient. In the absence of a pulse, the course of action would be to initiate a code blue and notify the charge nurse or supervisor.

Regarding the second patient, if I observed the nurse intending to perform the aseptic treatment without adhering to hand hygiene protocols or donning gloves, I would communicate with the nurse and stress the importance of following the required safety protocols for the procedure. In the event that the nurse refused to use hand hygiene or sterile gloves to perform the procedure, I would immediately contact the charge nurse in order to protect the patient from potential infection.